Dear Rep Marsh,

As a follow-up to today's meeting here is the reference to my statement that DHHS is instructing the physician not
to run the Western blot after a negative Elisa. So how do we rule out a false negative Elisa?

Clearly the Dept. of Health receives its marching orders from the CDC and it's time for change.

I would like this communication posted to the Commission website under the Right-to-Know law.

THIS IS AN OFFICIAL NH DHHS HEALTH ALERT
https://www.dhhs.nh.gov/dphs/cdcs/alerts/documents/lyme-2015.pdf

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Excerpt:

Testing: Laboratory testing should be used to support clinical suspicion of disease based on
presenting signs and symptoms and a history of possible exposure to infected ticks. Within 4
weeks of infection, ***Borrelia burgdorferi*** antibodies can be detected using FDA-approved serologic testing. The CDC currently recommends a two-stage testing approach with the first
step involving an ELISA as the screening test, and if positive or equivocal confirmed by Western
Blot. A Western Blot should not be run if the initial ELISA test is negative. A patient is considered to have a positive Lyme Western Blot test if 2 of 3 IgM bands are reactive (24, 39,
41 kDa) OR if 5 of 10 IgG bands are reactive (18, 21, 28, 30, 39, 41, 45, 58, 66, 93 kDa). An
isolated positive IgM (without a positive IgG) in a patient with tick exposure more than 8 weeks
prior is likely to be a false positive test, since IgG antibodies are produced within 4-8 weeks after
exposure. Only laboratories with validated and FDA-approved testing methods for Lyme ELISA
and confirmatory Western blot should be used for diagnosis of disease.

Respectfully Submitted,

Carl Tuttle

"If false results are to be feared, it is the false negative result which holds the greatest peril for the patient."
-Alan B MacDonald, Pathologist